



## Financial Assistance and Financial Aid Fund Application Form

Please Print Clearly:

### Personal Information Section

1. Applicants

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail: \_\_\_\_\_ Phone 1: (C) \_\_\_\_\_

Phone 2: (H) \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Parent / Guardian Name (If Minor): \_\_\_\_\_

### Financial need is being requested for?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

 Medical Alert ID

**Financial Need Requested:** \$ \_\_\_\_\_

*This request will be forwarded to the Financial Assistance Committee of Bleeding Disorders Association of South Carolina. In the interest of privacy, identifying information will be removed from the request and forwarded to a blinded committee for review. Additional information may be required. All payments will be made directly to the party that is owed the monies. Please attach all supporting information including copies of bills and payment page. Applicants will be informed of the outcome of the committee review.*

To the best of my knowledge, I hereby certify that the above information is correct and accurate.

\_\_\_\_\_ **Date:** \_\_\_\_\_

### Applicant (or parent/guardian)

Approved \_\_\_\_\_ Denied \_\_\_\_\_ Referred to HFA \_\_\_\_\_

Date: \_\_\_\_\_

Reason for denial (if applicable)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section 2 – Blinded Information for Submittal**

**The applicant is:**

- An adult with a bleeding disorder
- A caretaker of someone with a bleeding disorder living in your household
- A parent of a minor child with a bleeding disorder. Please include the age of the child with the bleeding disorder (\_\_\_\_\_) years.
- Other, please explain \_\_\_\_\_

**How many family members in your household?**

Adults: \_\_\_\_\_ Children (Under 18) \_\_\_\_\_

**Did someone refer you to the BDASC Financial Aid Program?** Yes \_\_\_ No \_\_\_

If referred, who is making the referral services? \_\_\_\_\_

**Have you applied for assistance from any other sources, and if so, what is the status of that application?**

\_\_\_\_\_

**What is the applicant’s annual household income?**

- Unemployed
- Less than \$15,000
- \$16,000 - \$35,000
- \$36,000 - \$50,000
- \$51,000 or greater

**Employer:** \_\_\_\_\_

Address of Employer: \_\_\_\_\_

Phone Number of Employer: \_\_\_\_\_

**Creditor:** Please supply the business or individual whom BDASC should make payment:

Name: \_\_\_\_\_

Complete Address: \_\_\_\_\_

Account / Invoice Number: \_\_\_\_\_

**HTC and Physician:**

\_\_\_\_\_ **Phone Number** \_\_\_\_\_

Have you applied for assistance from BDASC in the past year? Provide date: \_\_\_\_\_

**Pease mail or fax in the application to:**

**Bleeding Disorders Association of South Carolina, Attn: Financial Assistance Program**

**(See address information in the footnote section)**